

# **MEDICARE LEARNING NETWORK - COMPUTER/WEB-BASED TRAINING**

## **WOMEN'S HEALTH**

Welcome to Steps to Promoting Wellness: Women's Health.

*My name is Constance Virgil, and I am a Health Care Promoter for Medicare. The goal of this Women's Health Computer Based Training (CBT) module is to promote wellness and increase the utilization of routine screening for female beneficiaries, and help providers build their practices by promoting the use of preventive services covered by Medicare. More detailed information about Medicare, including information on other CBT courses and satellite broadcasts, can be obtained by visiting the "Learning Resources" section of HCFA's website at [www.hcfa.gov](http://www.hcfa.gov), or by calling your local Medicare contractor.*

*Medicare covers preventive services such as mammograms, pap tests, pelvic exams, clinical breast exams, and colon screenings. So now, it is my responsibility to ensure that physicians and health care providers across the nation understand that certain routine Women's Health screenings ARE payable under the Medicare program. Therefore, we have designed this training to increase your awareness of the Women's Health benefits that are covered under the Medicare program.*

### Women's Health - Introduction

This course begins with a brief Preliminary Knowledge Assessment so you can gauge your understanding of Medicare's covered benefits for women's health screenings, and your knowledge of coverage requirements for these benefits.

After you complete the preliminary assessment, you will continue to the lesson menu. The first lesson in the course provides a detailed overview of Medicare's coverage and diagnosis requirements for mammograms, as well as reimbursement policies, Unique Physician Identification Number (UPIN) requirements and written advance notification requirements.

After the mammogram section, the course continues with information on pap tests, pelvic exams, and colorectal exams. At the conclusion of each lesson, you will be asked to answer a few review questions. These questions will show you which areas of the lesson, if any, you need to review before moving on in the course material. At the end of the course, there is a brief Post-Course Knowledge Assessment that will test your understanding of the material covered. Once you have completed the course and the post-course assessment, you can print your progress report with your scores for both the pre- and post-assessments, along with your course completion certificate.

This course should take you approximately 60 minutes to complete. Upon completion of this course you will be able to:

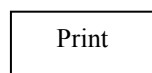
- Describe Medicare's coverage criteria as it relates to mammograms, pap tests, pelvic exams, and colorectal screenings;
- Distinguish between a screening and a diagnostic mammogram;
- Explain the appropriateness of billing Medicare for a diagnostic mammogram after performing a screening mammogram (same date of service);
- Explain how to appropriately bill for mammograms, pap tests, pelvic exams, and colorectal screenings;
- Explain documentation requirements for mammograms, pap tests, pelvic exams, and colorectal screenings; and
- State Medicare's policy as it relates to mammograms, pap tests, pelvic exams, and colorectal screenings.

Throughout the course, on-screen text and images will be used to present the course information. Along with these images and text, you will have an active menu at the right of your screen. This menu includes the Exit button, Course Map button, Glossary button, Menu button, and Options button, along with standard Previous (left arrow) and Next (right arrow) navigation buttons. If any of these buttons are gray, it means that the button is inactive. For example, in the pre-assessment, the Course Map and Menu buttons are not active to ensure that you answer each question in chronological order before continuing with your training.

At certain times in the course you will also see an Example button and a Print button.



The Example button will active a separate text window with Information on the specific topic being presented. The Print Button will print the current document.



There will be instances when you can click on other images within the course to obtain more information.

To begin your training on Medicare's Women's Health benefits, click on right arrow to enter the pre-assessment.

Be sure to read the "prompt line" for instructions and information on when these additional informative images are available.

### Preliminary Knowledge Assessment

This course begins with a brief Preliminary Knowledge Assessment so you can gauge your understanding of Medicare's covered benefits for women's health screenings and your knowledge of coverage requirements for these benefits.

After you have completed this preliminary assessment, you will be asked to answer a series of questions about Medicare's Women's Health benefits. After you have answered all of the questions, you will be given feedback on your current knowledge of the course subject matter.

What determines which type of mammogram should be billed to Medicare?

- The physician's order/patient's request.
- The number of views taken.
- The nurse's medical opinion.
- All of the above.

True or False? A provider should include the "GH" modifier after the diagnostic mammogram procedure code when the interpretation of a screening mammogram results in a diagnostic mammogram.

- True
- False

True or False? The physician's name and Unique Physician Identification Number (UPIN) is required on all claims submitted for screening mammograms.

- True
- False

Medicare coverage allows for women who are at low risk to have a pap test ...

- Once every year.
- Once every other year.
- Once every three years.
- Once in a lifetime.

True or False? Medicare's coverage allows beneficiaries who are at high risk for cervical/vaginal cancer to receive a pap test as often as is medically necessary.

- True
- False

If a provider renders both a screening pap test and a screening pelvic exam on the same day, Medicare will ...

- Deny one as it will be included in the allowance of the other.
- Deny both services and request the provider to resubmit one or the other.
- Reimburse them both except if the service is denied for other reasons.
- Contact the treating physician immediately.

If a patient enters the office with a physician's order to have a screening mammogram performed and an irregularity is detected on the film of the screening mammogram, the radiologist should ...

- Request that the patient return to the office the next day; bill Medicare for the screening mammogram for that day; and bill for the diagnostic mammogram on the following day (when the patient returns).
- Immediately perform a diagnostic mammogram to confirm findings; bill Medicare for both the screening mammogram and the diagnostic mammogram (same day of service).
- Take additional views (or films) and use the CPT code to denote a diagnostic mammogram; only bill Medicare for the diagnostic mammogram.
- Contact the treating physician immediately.

True or False? Medicare coverage allows for women to have a pelvic exam once every other year.

- True
- False

True or False? Medicare beneficiaries are NOT required to exhibit any signs or symptoms in order to qualify for coverage of a colorectal screening.

- True
- False

When billing for a fecal-occult blood test which requires 3 simultaneous determinations, what number should be reflected in the days of units/units field?

- "1"
- "3"
- "6"
- None of the above.

You have scored \_\_\_\_ correct on the Preliminary Knowledge Assessment.

To review the correct answers, click on the numbered boxes below. The red boxes indicate an incorrect answer, and the green boxes indicate a correct answer.

It is advised that you proceed through all of the sections of the course, beginning with lesson one, to increase your understanding of Medicare's preventive benefits of Women's Health.

After completing all of the course lessons, you can proceed to the Post-Course Knowledge Assessment. After completing the post assessment, you can review your final score and receive your course certification.

Click the right arrow to begin your training.

Learn about women's health from the following lessons:

- Mammograms
- Screening Pap Tests
- Screening Pelvic Exams
- Colorectal Screenings
- Post-Course Knowledge Assessment

## Mammograms

### Introduction

There are two types of mammograms that are covered under the Medicare program, screening and diagnostic. I will first explain the difference between the two.

A diagnostic mammogram is a non-routine examination performed on beneficiaries who: have distinct signs and/or symptoms for which a mammogram is indicated; have a history of breast cancer; and/or, are asymptomatic but received a physician's recommendation for a mammogram based on their history and/or other significant factors, beneficiaries who present with any of the above indications are generally classified as high risk. In order for Medicare to consider payment of the diagnostic mammogram, a written order/referral from the patient's treating physician is NOT required.

On the other hand, a screening mammogram is defined as a routine examination for the early detection of breast cancer. The patient typically has not manifested any clinical signs, symptoms, or physical findings of breast cancer. Beneficiaries who present without any signs/symptoms of having breast cancer are generally classified as low risk, and an order/referral from the patient's treating physician is NOT required.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) allowed Medicare to begin coverage of screening mammograms. This Act authorized Medicare to cover screening mammograms provided to female beneficiaries on or after January 1, 1991. The statutory required frequency parameters associated with this Act of 1990, were more stringent than they are today. OBRA of 1990 allowed Medicare to cover screening mammograms once every two years for those beneficiaries who were classified as low risk, and once a year for those beneficiaries who were classified as high risk.

Recently, the Balanced Budget Act (BBA) of 1997 modified the guidelines that were in existence. This new legislation allows a female beneficiary between the ages of 35 and 39 to receive one baseline mammogram, and beneficiaries aged 40 and older to receive one screening mammogram annually. But, did you know that although Congress has extended Medicare's coverage of this benefit, screening levels remain dangerously low? It is vital to our healthcare communities that we do everything within our means to increase the percentage of beneficiaries receiving routine screenings for mammogram services.

In this lesson of the course, you will learn quite a bit about mammograms, include facility certification requirements, coverage guidelines, utilization of the appropriate procedure code, diagnosis requirements, coding guidelines, and Medicare's reimbursement policy for screening mammograms. Additionally, you will receive coding tips, advice on the appropriateness of using the treating physician's UPIN, and information on the written advance notification form as it relates to screening mammograms.

There is a lot to learn, so let's get started. Click the right arrow to continue.

### Facility Certification Requirements

As you may be aware, when billing Medicare for a screening mammogram, there are specific requirements governing the beneficiary, the procedure code, and the diagnosis code - we will cover these requirements later in the training. But did you know that there are also requirements for facilities that allow mammograms to be performed on site? In fact, in order to receive reimbursement from Medicare, the facility where the service is being rendered must meet certain national requirements. One requirement is compliance with the Mammography Quality Standards Act (MQSA). In essence, compliance with the MQSA requires that before performing a mammogram on a Medicare beneficiary, the facility where the service is being provided must be accredited by a designated Accreditation Body and certified by the Food and Drug Administration (FDA) or the states of Iowa or Illinois. This certification is necessary for facilities that provide both screening and diagnostic mammograms.

To become a certified mammography facility, the FDA requires that the facility receives accreditation through the American College of Radiology (ACR) unless the facility is located in one of the following four states.

- The State of Arkansas (SAR);
- The State of Iowa (SIA);
- The State of California (SCA); or
- The State of Texas (STX).

In these cases, the facility may apply for accreditation through either the ACR or the appropriate State Department of Radiation Protection in which it is located.

Once your facility becomes accredited, you will receive a certificate from either the FDA or the States of Iowa or Illinois (if the facility is located within these states). After your certificate is processed, it will be forwarded to the Health Care Financing Administration (HCFA) which will provide your FDA Facility Identification Number to the carrier. Once you receive your certificate, you will notice your six-digit FDA Facility Identification Number. This number is very important. The next step is to provide a copy of your certificate to your local provider enrollment department. When your certificate is received, it will then be placed on file at Medicare for verification purposes.

As mentioned, your six-digit FDA Facility Identification Number is very important. In fact, when billing Medicare for mammography services, you must always indicate this number in block 32 of the HCFA-1500 claim form or in EAO record, field 31, positions 142-151 if submitting claims electronically using the National Standard Format (NSF). In cases where a provider omits the facility certification number from the claim form, Medicare will deny payment of the mammogram. The same holds true for providers who render services at non-certified facilities or facilities with suspended or revoked certificates. So, it is very important that you make sure that the facility's six-digit FDA Facility Identification Number is indicated on the claim form each time you submit a claim to Medicare for reimbursement of a mammogram procedure.

For more information on becoming accredited by the ACR, telephone them directly at 1-800-227-5463. The ACR will instruct you on proper procedures for obtaining ACR accreditation. For state accreditation in Arkansas, California, Iowa, or Texas, you should contact the appropriate State Department of Radiation Protection.

### Coverage Requirements - Screening Mammograms

Medicare has coverage requirements that must be met in order for a screening mammogram to be considered for payment. One requirement is that the beneficiary does not exceed Medicare's statutory frequency parameters. Medicare's statutory frequency parameters vary by age group. For example,

Medicare allows one baseline screening mammogram for beneficiaries in the age group of 35 to 39 years. It allows one screening mammogram a year for those beneficiaries aged 40 and over, as long as 11 full months have elapsed following the month of the last screening.

Although Medicare requires the beneficiary to wait one full year prior to having their next screening mammogram, it is appropriate for a beneficiary to return to the physician's office to have a diagnostic mammogram (if an irregularity is detected) prior to the passing of a year after the screening mammogram was performed.

Example
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Medicare has coverage requirements that must be met in order for a diagnostic mammogram to be considered for payment. One requirement is that the beneficiary must present with a written order from their attending physician. Unlike screening mammograms, there are no statutory frequency parameters in place for the diagnostic mammogram. For example, if the attending physician orders a diagnostic mammogram and orders the patient to have another diagnostic mammogram performed six months later, Medicare will allow coverage for both mammograms.

#### Coding Requirements - Procedure Codes

There are three different ways that a provider can bill Medicare for a mammogram procedure:

- The first method is to bill for the global/complete service (i.e., 76090). The provider bills this method when she/he performs both the professional component and the technical component.
- The second method is to bill for the professional component only (i.e., 76091-26). The provider bills this method when she/he only does the interpretation of the film.
- The third method is to bill Medicare for the technical component only (i.e., 76092-TC). The provider bills this method if she/he provides only the technical component of the service.

Once a facility has been certified, and the beneficiary has received the service, it is now time to file the claim. The proper procedure code must be submitted on the claim in order for Medicare to consider it for payment. And, since there is only one procedure code for the screening mammogram, the selection is simple. The CPT code for the screening mammography is:

Procedure Code  
76092

Descriptor  
Screening mammography, bilateral

As previously mentioned, a screening mammogram is a mammography performed on an asymptomatic patient to detect the presence of breast cancer at an early stage. When a screening mammogram is performed and the radiologist feels the need to order additional film based upon his/her interpretation of the screening films, Medicare allows the radiologist to order additional film/views and bill for a diagnostic mammogram.

Example

It is important to remember that billing Medicare for a diagnostic mammogram when the initial intent was for a screening mammogram is only allowed if the radiologist finds an irregularity while interpreting the screening mammogram.

If a radiologist performs a screening mammogram and then orders a diagnostic mammogram as a result of irregular findings (on the same day), the only service that the radiologist should bill to Medicare is the diagnostic mammogram. Only one service should be submitted. If both services are submitted, Medicare will deny one service as included in the allowance of the other. Additionally, when this situation occurs, the "GH" modifier should accompany the diagnostic mammogram procedure code (i.e., 76091-GH). This modifier informs Medicare that the initial intent of the exam was for a screening mammogram, but the results of the screening made it necessary to order a diagnostic mammogram. Because the "GH" modifier serves as a tracking mechanism for Medicare, it is very important to include it when appropriate.

There are two procedure codes to select from when billing Medicare for a diagnostic mammogram. The appropriate code depends upon whether you are examining one breast (unilateral) or both breasts (bilateral). The CPT codes for the diagnostic mammograms are:

Procedure Code	Descriptor
76090	Diagnostic mammography, unilateral
76091	Diagnostic mammography, bilateral

It is inappropriate for a provider to submit a claim to Medicare with both diagnostic mammogram procedure codes present. When this occurs, one code will deny as included in the basic allowance of the other.

Now that you understand the certification process and Medicare's coverage requirements for mammograms, let's move on to learn about Intermediary coding requirements for these screenings.

### Intermediary Billing Requirements

Although all three billing methods (global, professional, and technical) are acceptable when billing Medicare, global billing (billing for both the professional and technical components) is not permitted for services furnished in outpatient settings. If services are rendered in an outpatient facility setting, the provider should bill the intermediary for the technical component only using the HCFA-1450/UB92 claim form (the professional component should be billed to the carrier using the HCFA-1500 claim form).

- When billing the technical component using the HCFA-1450 claim form, the bill type used should be 14X, 71X (provider ranges 3400-3499, 3975-39999, and 8500-8899) or 85X.
- If you are uncertain about which bill type you should use, please contact your intermediary.
- When billing the intermediary, the appropriate revenue code to report is 403, which should be used in conjunction with procedure code 76092.
- The beneficiary's age, diagnosis, and date of last screening mammogram should be reported in the appropriate fields on the claim form.
- It is also important to remember that when billing a screening mammogram to the intermediary, no other service(s) should be included on the claim; this service should be submitted alone.

NOTE: Whenever the radiologist's interpretation of a screening mammogram results in the need for additional films, the mammogram is no longer considered a screening exam for payment purposes. When this situation occurs in the outpatient setting, the provider should bill the intermediary using revenue code 401 in conjunction with the procedure code 76090 or 76091, followed by the "GH" modifier.

### Diagnosis Requirements - Screening Mammograms

In addition to the appropriate procedure code, Medicare has specific diagnosis requirements that should be considered when billing screening mammograms. In fact, just as with the procedure code, there is only one diagnosis code that should be submitted when billing for the screening mammogram. The appropriate diagnosis code to submit is:

<u>ICD-9 code</u>	<u>Description</u>
V76.12	Other screening mammography

### Diagnosis Requirements - Diagnostic Mammograms

As you can see, there is only one diagnosis code a provider can use when billing Medicare for a screening mammogram. On the other hand, there are many diagnosis codes to choose from when billing Medicare for a diagnostic mammogram. Because the diagnosis requirements for a diagnostic mammogram vary by state, you should contact your local carrier for more information regarding appropriate diagnosis codes to report when billing for a diagnostic mammogram.

### Unique Physician Identification Number (UPIN)

For any Medicare covered service that is referred/ordered by a physician, the treating physician's name and UPIN are required on the HCFA-1500 claim form, as well as on claims that are transmitted electronically. On the HCFA-1500 claim form, the treating physician's name should be indicated in block 17 and the corresponding UPIN should be indicated in block 17a. For claims submitted electronically, this information should be placed in EAO fields 20 and 22-24; positions 80-94 and 120-152, if using the National Standard Format (NSF).

When a radiologist orders additional films based on abnormal findings of a screening mammogram, the radiologist should refer back to the treating physician to obtain his/her UPIN.

## Reimbursement Policy

Just like the procedure code and diagnosis code requirements for screening mammograms, Medicare's reimbursement policy is straightforward and easy to understand. The following information outlines Medicare's reimbursement policy as it relates to mammograms.

Under Medicare's reimbursement policy for mammogram services, the Part B deductible is waived, but the 20% coinsurance is applicable. Participating providers can collect this amount at the time of service if they so desire. Non-participating providers, who do not accept assignment, have the option to collect payment for their services (in full) at the time that the service is rendered.

In addition, Medicare places limitations on the amount that a provider can charge for mammogram services. Medicare restricts its allowable amount to the lowest of the actual charge, the statutory cap, or the physician fee schedule amount for the diagnostic mammogram (procedure code 76091 - diagnostic mammogram; bilateral). The actual allowable amounts for 1999 are as follows:

<u>Procedure Code</u>	<u>Nationwide Allowable Amount</u>
76092 (global)	\$66.22
76092-26 (professional)	\$21.19
76092-TC (technical)	\$45.03

The above amounts are Medicare's allowable charges. This is the maximum amount reimbursed. If the amount charged is less than the above, the lesser amount should be allowed. If the amount charged is greater than the above, then the above amount should be allowed. That is all there is to Medicare's reimbursement policy for screening mammograms. Click the right arrow to learn about advancement notice requirements.

## Written Advance Notice Requirements

A written advance notice should be provided to a beneficiary when billing for a service that could potentially be denied by Medicare (i.e., the beneficiary exceeds statutory required frequency parameters or the beneficiary does not meet diagnosis coverage criteria). If the provider does not want to accept financial responsibility for services that have statutory required frequency parameters, then an acceptable written advance notice of Medicare's possible denial of payment must be given to the patient. Medicare's position on providing a beneficiary with a written advance notice prior to rendering a screening mammogram is that since beneficiaries are informed of mammogram utilization parameters in their Medicare Handbook and on their Medicare Summary Notices (MSNs), it is not mandatory that the physician have the beneficiary sign an advance notification form.

Additionally, the MSN that the beneficiary receives provides a complete account of services rendered and the amount of co-insurance that is due to the physician. Therefore, it is up to the beneficiary to ensure that they do not exceed Medicare's statutory frequency parameters since they can be held financially liable if they do. Remember, the deductible is waived when receiving mammography procedures.

### Documentation Requirements

When treating a Medicare beneficiary, the treating physician must maintain medical records documenting the need or medical necessity for performing and/or ordering services. The documentation may be included in any of the following:

History and physical;  
Office notes; and/or  
X-ray/radiology with written interpretation.

### Coding Tips

Neither a physician's order, nor a referral is required in order for a screening mammogram to be considered for payment. In fact, the beneficiary may determine the necessity of having a screening mammogram performed. And, to take this a step further, there may not be a necessity at all.

A beneficiary's desire is reason enough to have this procedure performed. However, the provider must keep in mind that even though this services does not require a written order or referral from the treating physician, Medicare will only consider payment for those screening mammograms that are performed within their established guidelines. And, although a written order is not required, some physicians send their patents to the radiologist with an order/referral.

In the cases when a physician does order mammogram services, the type of mammogram that the beneficiary is to receive must be clearly indicated on the physician's order. And, the physician must ensure that the date of the beneficiary's last screening mammogram is also on the order. Including this information on the order helps to ensure that entities that furnish mammograms are providing the proper service to Medicare beneficiaries.

### Lesson Review

A screening mammogram becomes a diagnostic mammogram only when more than two views are taken (e.g., type of mammogram is based on the number of views).

- True
- False

True or False? A written advance notice should be provided to the patient if she is over the age of 40 and receives more than one mammogram within a one-year period.

- True
- False

A mammogram consisting of two views of each breast is ...

- Always a screening mammogram.
- Always a diagnostic mammogram.
- A screening or a diagnostic mammogram depending upon the physician's order/patient's request.
- None of the above.

Once a facility is certified to have mammogram procedures rendered from its site, where should the facility send a copy of their certificate?

- The Health Care Financing Administration.
- The American Medical Association.
- Their local Medicare provider enrollment department.
- The Food and Drug Administration.

Congratulations. You have now completed the Mammograms section. Click the right arrow to continue and select Screening Pap tests from the Menu.

### Screening Pap Tests

#### Introduction

One of the main responsibilities of my job is to increase awareness of the need for regular Papanicolaou (pap) tests, and Medicare's coverage of these routine screenings. Cervical cancer can affect women in any age group. Since its introduction in the early 1940's, the pap test is credited with saving tens of thousands of women's lives and decreasing deaths from cervical cancer by more than 70%. The key to its success is early detection made possible by microscopic examinations of a specially treated sample of cervical cells. So, let's learn more about these beneficial tests. Click on the right arrow to continue.

#### Coverage Requirements and Risk Factors

For low risk beneficiaries (i.e., exhibit no signs/symptoms), Medicare covers pap tests once every three years. For beneficiaries who are at high risk (i.e., exhibits certain signs or conditions consistent with cervical and vaginal cancer), Medicare pays for more frequent screening pap tests.

The following factors determine the high risk level for cervical cancer: onset of sexual behavior prior to age 16; multiple sexual partners - defined as five or more in a lifetime; a history of sexually transmitted disease - including HIV infection; and fewer than three negative pap tests within the previous seven years. If any or all of these factors apply, the beneficiary is considered high risk and Medicare will cover her pap tests on an "as needed" basis rather than once every three years.

All screening pap tests that are submitted to Medicare must be ordered and collected by a doctor of medicine or osteopathy, or other practitioner such as a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist. In addition, the tests must be administered under one of the two following conditions.

- The first condition is that the beneficiary is low risk, and has not had a screening pap test performed during the preceding three years.
- The second condition is that there is evidence, on the basis of the beneficiary's medical history (or other findings), that the patient of childbearing age and has had an examination which indicated the presence of cervical cancer, vaginal cancer, or any other irregularity during the preceding three years, or that she is at high risk of developing cervical or vaginal cancer.

For beneficiaries who are not considered high risk, Medicare covers screening pap tests once every three years. But, as we learned earlier, women who are considered high risk for developing cervical or vaginal cancer qualify for more frequent pap tests under Medicare coverage guidelines.

You have now completed the lesson on screening pap test coverage requirements. Click the right arrow to continue and learn about the proper procedure codes to utilize when billing Medicare for these services.

### Coding Requirements - Procedure Codes

Medicare uses various procedure codes for reporting screening pap tests, the interpretation of screening pap tests, and the conveyance of these screening tests to outside laboratories. We will take a look at all of these codes in this section of the course.

Selection of the appropriate code depends on the reason for performing the test, the method of specimen preparation and evaluation, and the reporting system used. Please be advised that two of the three screening pap interpretation codes have become professional physician interpretation codes only and can no longer be used to report technical components.

### 1) Recording of HCPCS Codes for Pap Tests

There are several HCFA Common Procedure Coding System (HCPCS) codes (click the appropriate print button below for a list) that are used to report screening pap tests. The proper code to select depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used. The HCPCS codes used to report screening pap tests are listed below:

- P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears, (any reporting system), evaluation by cytotechnologist under physician supervision.
- G0123 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, evaluation by cytotechnologist under physician supervision.
- G0143 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and reevaluation by cytotechnologist under physician supervision.
- G0144 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer assisted reevaluation by cytotechnologist under physician supervision.
- G0145 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer assisted reevaluation using cell selection and review under physician supervision.
- G0145 Screening cytopathology, cervical or vaginal; performed by automated system under physician's supervision.
- G0148 Screening cytopathology smears, cervical or vaginal; performed by automated system with manual reevaluation.

As you know, there are various CPT codes to report diagnostic pap tests. In fact, each HCPCS code used to report a screening pap test has a correlating CPT code used to report a diagnostic pap test. Click on the print button below for a printable table that shows the various HCPCS codes used for screening pap tests (alpha-numeric codes) and the related CPT codes used for diagnostic pap tests (all numeric codes) as well as CPT terminology for both screening and diagnostic pap tests.

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### *Screening Pap Tests - Coding Requirements, Procedure Codes*

*There are seven HCFA Common Procedure Coding System (HCPCS) codes that are used to report screening pap tests. The proper code to select depends on the reasons for performing the test, the methods of specimen preparation and evaluation, and the reporting system used. The HCPCS codes used to report screening pap tests are listed below.*

- *P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears, (any reporting system), evaluation by cytotechnologist under physician supervision.*
- *G0123 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, evaluation by cytotechnologist under physician supervision.*
- *G0143 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and reevaluation by cytotechnologist under physician supervision.*
- *G0144 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer assisted reevaluation by cytotechnologist under physician supervision.*
- *G0145 Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer assisted reevaluation using cell selection and review under physician supervision.*
- *G0147 Screening cytopathology, cervical or vaginal; performed by automated system under physician supervision.*
- *G0148 Screening cytopathology smears, cervical or vaginal; performed by automated system with manual reevaluation.*

<i>Method of slide evaluation</i>	<i>Thin layer preparation Reporting system not specified</i>	<i>Conventional Preparation</i>		
		<i>Non-Bethesda Reporting</i>	<i>Bethesda Reporting</i>	<i>Reporting System not specified</i>
<i>Manual screening</i>	<i>88142 G0123</i>	<i>88150 P3000</i>	<i>88164 P3000</i>	
<i>Manual screening and re-screening</i>	<i>88143 G0143</i>	<i>88153 P3000</i>	<i>88165 P3000</i>	
<i>Manual screening and computer assisted re-screening</i>	<i>88144 G0144</i>	<i>88152 P3000</i>	<i>88166 P3000</i>	
<i>Manual screening and computer assisted re-screening using cell selection</i>	<i>88145 G0145</i>	<i>88154 P3000</i>	<i>88167 P3000</i>	
<i>Automated screening</i>				<i>88147 G0147</i>
<i>Automated screening and manual re-screening</i>				<i>88148 G0148</i>

In addition to the seven HCPCS codes used to report screening pap tests, there are another three HCPCS codes that the physician should use to report the interpretation of a screening pap test.

## 2) Interpretation of HCPCS Codes for Pap Tests

The HCPCS codes (click the print button below for a list) used to report the physician's interpretation of screening pap tests are as follows:

- G0124 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by a physician.
- G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual re-screening, requiring interpretation by a physician.
- P3001 Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by a physician.

### Screening Pap Tests - Interpretation Codes

The HCPCS codes used to report the physician's interpretation of screening pap tests are as follows:

- *G0124 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by a physician.*
- *G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual re-screening, requiring interpretation by a physician.*
- *P3001 Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by a physician.*

### Screening Pap Tests

#### Coding Requirements - Procedure Codes

Finally, there is one HCPCS code that is designed for providers to use when they obtain, prepare, and convey the test, and then send the specimen to an outside laboratory. The correct code for this procedure is:

Q0091 Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory.

#### Intermediary Billing Requirements

For facilities that bill the intermediary for screening pap tests, bill types 13X, 14X, 23X, 24X, or 71X should be submitted. Each intermediary has the option to accept other bill types. If you are uncertain about which bill type you should use, please contact your intermediary.

The correct revenue code to submit on the HCFA-1450/UB92 claim form is 311 (cytology), and when using bill type 13X, 14X, 23X, or 71X, the appropriate screening pap test HCPCS code should also be submitted in order for Medicare to consider the claim for payment.

### Diagnosis Codes

When billing for a screening pap test, the provider should use one of two different ICD-9 codes. The specific diagnosis code to use is solely dependent on the beneficiary's condition. For example, Medicare covers screening pap tests for beneficiaries who are classified as low risk (having no signs/symptoms indicating the possibility of having cervical/vaginal cancer) as well as those beneficiaries who are classified as high risk (having signs/symptoms which indicate the possibility of having cervical/vaginal cancer). The following information provides

you with the appropriate diagnosis code to submit, depending upon the beneficiary's classification:

- Low Risk - The appropriate diagnosis code to report for those beneficiaries who are classified as low risk is: V76.2 - special screening for malignant neoplasm, cervix.
- High Risk - The appropriate diagnosis code to report for those beneficiaries who are classified as high risk is V15.89 - other specified personal history presenting hazards to health.

### Reimbursement Guidelines

All pap tests are reimbursed in accordance to the physician's fee schedule, with the exception of P3000 (which is reimbursed under the clinical laboratory fee schedule and paid at 100%). Medicare pays 80% of the physician's fee schedule amount or the provider's actual charge - whichever is lower. Additionally, the Part B deductible is waived for those screening pap tests that are paid under the physician's fee schedule.

### Coding Requirements - Procedure Codes

When treating a Medicare beneficiary, the treating physician must maintain medical records documenting the need or medical necessity for performing and/or ordering services. Documentation to support the beneficiary's need of a pap smear includes the following:

- History and physical;
- Office/progress notes; and
- Pathology report with written interpretation.

This documentation should be maintained in the patient's permanent records, and should be readily available in the event of a review request.

Now that we have covered the coverage guidelines, billing/coding, reimbursement, and documentation requirements for screening pap tests, click the right arrow to continue your training and complete the lesson review.

### Lesson Review

When a pap test is billed in addition to an evaluation and management (E/M) service (on the same day by the same provider), the pap test will ...

- Be reimbursed at 1/2 of its original fee.
- Be reimbursed in addition to the E/M service.
- Be denied as included in the reimbursement of the E/M service.
- None of the above.

How do regular pap tests help in the fight against cervical cancer?

- They help to find and diagnose the signs of precancerous growth in the cervix.
- They treat cervical cancer so that it will never return.
- They place patients with cervical cancer into remission.
- None of the above.

True or False? If a Medicare beneficiary qualifies as a high-risk individual for cervical or vaginal cancer, she qualifies for pap tests more frequently than once every three years.

- True
- False

How many HCPCS codes are there to select from when billing for the interpretation of screening pap tests?

- Three.
- Four.
- Seven.
- Thirteen.

Congratulations. You have now completed the Screening Pap Tests section. Click the right arrow to continue, and select Screening Pelvic Exams from the Menu.

### Screening Pelvic Exams

#### Introduction

The pelvic exam is an important component of women's preventive health care. It is essential for early detection and, therefore, better management of genital cancer, infections, sexually transmitted diseases and other irregularities. In a pelvic exam, the uterus, vagina, ovaries, fallopian tubes, bladder, rectum and breasts are inspected to diagnose any irregularity in their shape and/or size. Let's learn more about pelvic exams and Medicare's coverage of these potentially life-saving examinations. Click the right arrow to continue.

#### Coverage Requirements

The Balanced Budget Act of 1997 includes coverage for screening pelvic exams as a covered benefit under the Medicare Part B program for female beneficiaries. This coverage became effective as of January 1, 1998, and this provision includes coverage of the pelvic exam once every three years or more frequently

for women who exhibit certain signs or conditions. These signs or conditions include women who are at high risk for developing cervical or vaginal cancer, and women who have had an examination during any of the preceding three years that indicated the presence of cervical or vaginal cancer. High-risk factors for cervical and vaginal cancer are the same as for pap tests, and are founded on the basis of the beneficiary's medical history or other findings. Women who are considered high risk for developing cervical or vaginal cancer are allowed to have screening pelvic exams on an "as needed" basis as opposed to once every three years. For more detailed information on the factors involved in determining high-risk status, see the Screening Pap Tests lesson, Coverage Requirements and Risk Factors section.

To qualify for Medicare coverage, all screening pelvic exams must be ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner such as a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist. And, the exam must be administered under one of the two following conditions. The first condition is that the beneficiary has not had a screening pelvic exam during the preceding three years and is at low risk (does not exhibit any signs or symptoms) for developing cervical or vaginal cancer. The second condition is that there must be evidence, on the basis of the beneficiary's medical history or other findings, that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other irregularities during any of the preceding three years so that she is at high risk (has signs/symptoms or a family history) of developing cervical or vaginal cancer.

In addition, in order for Medicare to consider a pelvic exam for payment, certain coverage criteria must be met. Medicare will cover a screening pelvic exam if at least seven of the following eleven elements are performed. *(You can choose to print this list to keep for future reference by clicking on the PRINT button on your screen.)*

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;

*Pelvic examination, either with or without specimen collection for smears and cultures including:*

- External genitalia (i.e., general appearance, hair distribution, lesions, etc.)
- Urethral meatus (i.e., size, location, prolapse, etc.)
- Bladder (i.e., fullness, masses, tenderness, etc.)
- Vagina (i.e., general appearance, discharge, pelvic support, etc.)
- Cervix (i.e., general appearance, discharge, lesions, etc.)
- Uterus (i.e., size, contour, mobility, etc.)
- Adnexa/parametria (i.e., masses, tenderness, organomegaly, etc.)
- Anus and perineum.

You have now completed the lesson on screening pelvic exam coverage requirements. Click the right arrow to continue and learn about the proper procedure code and reimbursement guidelines for screening pelvic exams.

### Coding Requirements

Medicare acknowledges only one HCPCS code for reporting screening pelvic exams. The proper procedure code for screening pelvic exams is:

G0101 - Cervical or vaginal cancer screening; pelvic and clinical breast examination.

### Intermediary Billing Requirements

Facilities that bill the intermediary should use bill types 13X, 14X, 23X, 24X, or 71X. If you are uncertain about which bill type you should use, please contact your intermediary. The appropriate revenue code to submit is 770A (Preventive Care Services - General Classification).

### Diagnosis Requirements

Aside from using the appropriate procedure code and bill types, Medicare has specific diagnosis requirements that should be considered when billing pelvic exams. The first requirement is that the beneficiary has not had a screening pelvic exam during the preceding three years, and is at low risk for developing cervical or vaginal cancer. For this condition, the appropriate diagnosis code to use is:

V76.2 - special screening for malignant neoplasm, cervix.

The second requirement is that there must be evidence (on the basis of the beneficiary's medical history or other findings) that the beneficiary is of childbearing age and has had an examination that indicated the presence of

cervical or vaginal or other irregularities during any of the preceding three years, or that she is at high risk for developing cervical or vaginal cancer. For this condition, the appropriate diagnosis code to use is:

V15.89 - other specified personal history presenting hazards to health.

### Reimbursement Guidelines

The pelvic exam is reimbursed according to the physician's fee schedule. Medicare pays 80% of the physician's fee schedule amount, or the provider's actual charge - whichever is lower. Additionally, the Medicare Part B deductible is waived. However, the beneficiary is responsible for payment of their co-insurance.

*When submitting a claim to Medicare for reimbursement of a screening pelvic exam, proper coding is necessary. The following tips should help to ensure that you code the screening pelvic exam correctly. First, when a screening pap test and a pelvic examination are performed during the same encounter, both procedure codes should be shown as separate line items on the claim. Second, when the pelvic exam is billed in addition to an evaluation and management (E/M) service (procedure codes 99201-99215) on the same day by the same physician, the E/M service will be denied as "included in the allowance" of the pelvic exam.*

### Documentation Requirements

When providing a service to a Medicare beneficiary, the treating physician must maintain medical records documenting the need or medical necessity for performing or ordering services. Documentation to support the need of a pelvic exam includes the following:

- History and physical;
- Office notes; and/or
- Test results with written interpretation.

Congratulations, you have now completed the Screening Pelvic Exams lesson. Click the right arrow to continue your training and complete the lesson review.

## Lesson Review

When a screening pelvic exam is billed in addition to an evaluation and management (E/M) service (same date of service), the E/M service will ...

- Be reimbursed at 1/2 of its original fee.
- Be reimbursed in addition to the pelvic exam.
- Be denied as included in the reimbursement of the pelvic exam.
- None of the above.

True or False? There is only one procedure code that can be used to report a screening pelvic examination.

- True
- False

What are the factors for determining high-risk status for screening pelvic exams?

- Sexual history.
- Family history of cancer.
- Multiple factors - the same as for determining high-risk status for cervical and vaginal cancer.
- There is no high risk for screening pelvic exams.

True or False? To qualify for Medicare coverage, all screening pelvic exams must be ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner such as a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist who is authorized under state law to perform the examination.

- True
- False

*Congratulations. You have now completed the Screening Pelvic Exam lesson. Next, we will continue with the Colorectal Screenings lesson. Click the right arrow to continue, and choose Colorectal Screenings from the Menu to continue your training.*

## Colorectal Screenings

### Introduction

*Did you know that there is a silent killer that kills nearly 65,000 people each year? This silent killer is colon cancer - the second leading cause of cancer among men and women. Colon cancer arises from growths that develop on the*

*inner surface of the large intestine. Patients with colon cancer very rarely display any symptoms, and therefore the cancer can progress unnoticed and untreated until it becomes fatal. Colorectal screenings are performed to diagnose or determine a beneficiary's risk for developing colon cancer.*

*Effective for services furnished on and after January 1, 1998, Medicare will cover colorectal screenings for the early detection of colon cancer. If colorectal cancer is found early enough, there is a 90-percent chance of survival. With this in mind, it is obvious that the key to colorectal cancer is early prevention and regular screenings - including yearly screenings for persons aged 50 and older. And, since colorectal screenings have been proven to be effective in detecting early signs of colorectal cancer, it is critical that we increase the screening rates in our communities. Let's learn more about colorectal screenings, and Medicare's coverage of these potentially life-saving examinations.*

### Coverage Requirements

Colorectal examinations are subject to certain coverage, statutory required frequency parameters, and payment limitations. See the Statutory Required Frequency Parameters Section for more detailed information.

Medicare allows coverage of multiple procedures furnished to an individual for the early detection of colorectal cancer. These procedures include:

- Screening fecal-occult blood tests;
- Screening flexible sigmoidoscopy;
- Screening colonoscopy, for high risk individuals; and
- Screening barium enema as an alternative to a screening flexible sigmoidoscopy; or
- Screening colonoscopy.

There is a chart of Medicare approved procedure codes for colorectal screenings in the Coding Requirements - Procedures Codes section.

### Coding Requirements - Procedure Codes

There are various procedure codes for reporting colorectal screenings, as there are multiple screenings that can be performed and are covered under the Medicare program. We will take a look at all of these codes in this section of the course.

<u>Procedure</u>	<u>Description</u>
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GO107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations.
GO104	Colorectal cancer screening; flexible sigmoidoscopy;

GO105	Colorectal screening; colonoscopy on individual at high risk;
GO106	Colorectal screening; barium enema; as an alternative
GO120	Colorectal cancer screening; barium enema; as an alternative to GO105;
GO121	Colorectal cancer screening; colonoscopy on individuals not meeting criteria for high risk (non-covered); and
GO122	Colorectal cancer screening; barium enema (non-covered)

### Intermediary Billing Requirements

Providers who render colon cancer screenings in an outpatient setting should bill their intermediary using the HCFA-1450/UB92 claim form. Additionally, the provider should submit types 13X, 83X, or 85X. Each intermediary has the option to accept other bill types. If you are uncertain about which bill type you should use, please contact your intermediary. The provider should use either one of the following two revenue codes:

30X - Laboratory; Chemistry; or  
 32X - Radiology - Diagnostics; General Classification.

The following table is helpful when billing for any of the covered colorectal screenings:

<u>Screening Test/Procedure</u>	<u>Revenue Code</u>	<u>HCPSC Code</u>
Occult Blood Test	30X	GO107
Barium Enema	32X	GO106, GO120, GO122
Flexible Sigmoidoscopy	*	GO104
Colonoscopy High Risk	*	GO105, GO121

\*Use the appropriate revenue code for billing surgical procedures.

Listed below are examples of diagnoses that meet high-risk criteria for colorectal cancer; however, this is not an all-inclusive list. There may be other conditions that could be reported and would be applicable to this area. For this example, we will use three common categories: Personal History, Chronic Digestive Disease, and Inflammatory Bowel to display the correct ICD-9 codes that should be used.

Click the print button below for a copy of the following list.

### Personal History

- V10.05 Personal history of malignant neoplasm of large intestine
- V10.06 Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

### Chronic Digestive Disease

- 555.0 Regional enteritis of small intestine
- 555.1 Regional enteritis of large intestine
- 555.2 Regional enteritis of small intestine with large intestine
- 555.9 Regional enteritis of unspecified site
- 556.0 Ulcerative (chronic) enterocolitis
- 556.1 Ulcerative (chronic) ileocolitis
- 556.2 Ulcerative (chronic) proctitis
- 556.3 Ulcerative (chronic) proctosigmoiditis
- 556.8 Other ulcerative colitis
- 556.9 Ulcerative colitis, unspecified (non-specific PDX on the MCE)

### Inflammatory Bowel

- 558.2 Toxic gastroenteritis and colitis
- 558.9 Other and unspecified non-infectious gastroenteritis and colitis

### Colorectal Screenings

#### Statutory Required Frequency Parameters

There are a number of colon screenings that beneficiaries are eligible to receive. Please click the print button below for a list.

These statutory required frequency parameters determine the frequency that beneficiaries are eligible to receive colon screenings. The frequency is based on the type of examination provided.

That is all there is to Medicare's coverage guidelines for colorectal screenings. Let's move on the reimbursement guidelines. Click the right arrow to continue.

#### Reimbursement Guidelines

Fecal occult blood tests are reimbursed according to the clinical laboratory fee schedule. Medicare pays 100% of the clinical laboratory fee schedule amount or the provider's actual charge - whichever is lower. In addition, both the \$100 annual deductible and the 20% co-insurance amounts are waived.

#### Non-Covered Colon Screenings

The following colorectal cancer screenings are not covered benefits under the Medicare Part B program:

GO121 (Colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does not meet the criteria for high risk. This service is a non-covered Medicare service and the beneficiary is liable for payment.

CO122 (Colorectal cancer screening; barium enema) should be used when a screening barium enema is performed as an alternative to either a screening flexible sigmoidoscopy (GO104) or a screening colonoscopy (GO105). This service is a non-covered Medicare service and the beneficiary is liable for payment.

NOTE: Written advance notice does not apply to services that are non-covered under the Medicare program.

### Documentation Requirements

When treating a Medicare beneficiary, the treating physician must maintain medical records documenting the need or medical necessity for performing and/or ordering services. Documentation to support the need of a colon test includes the following:

- History and physical;
- Office notes; and/or
- Test results with written interpretation.

Congratulations. You have now completed the Colorectal Screenings lesson. Click the right arrow to continue your training and complete the lesson review.

### Lesson Review

How should a provider reflect a screening occult blood test that requires three simultaneous determinations?

- GO107 with a "1" in the days/units field
- GO107 with a "2" in the days/units field
- GO107 with a "3" in the days/units field
- None of the above.

True or False? There are certain conditions/diagnoses that qualify a patient as being high risk when having screening colorectal exams performed.

- True
- False

True or False? There are two screening colorectal procedures that are never covered under the Medicare program.

- True
- False

Congratulations! You have now completed the Women's Health training course. Click the right arrow to continue, and choose Post-Assessment from the Menu to complete the Post Course Knowledge Assessment and receive your completion certificate.

### Post-Course Knowledge Assessment

You should now have completed the entire course on Women's Health. The next step in getting your course completion certificate is to take the post-assessment. If you feel like you need to brush up on any of the information that we have covered, you should do so now. Once you have begun the post-assessment, the program will not allow you to go back into the course material until you have completed the assessment.

After you have completed the post-assessment, you will be given feedback on which questions you answered correctly, and you will have the option to print your "Progress Report" which contains the scores from both your pre- and post-assessment.

You may take the post-assessment as often as you like until you feel comfortable with your score.

To begin the assessment now, click the right arrow. To return to the course material, choose the Menu button.

### Post-Course Knowledge Assessment

What determines which type of mammogram should be billed to Medicare?

- The physician's order/patient's request.
- The number of views taken.
- The nurse's medical opinion.
- All of the above.

When a radiologist bills Medicare for a diagnostic mammogram, but the initial intent was for the patient to have a screening mammogram, which modifier should be reported at the end of the diagnostic mammogram procedure code?

- "GH"
- "QR"
- "LR"
- "CC"

True or False? The attending physician's name and Unique Physician Identification Number (UPIN) is required on all claims submitted for screening mammograms.

- True
- False

Medicare allows coverage for women who are at "low risk" to have a pap test ...

- Once every year.
- Once every other year.
- Once every three years.
- Once in a lifetime.

Beneficiaries who are at high risk for cervical/vaginal cancer may receive a pap test ...

- As often as medically necessary.
- Once every year.
- Once every other year.
- Once every three years.

If both a screening pap test and a screening pelvic exam are performed on the same day, Medicare will reimburse them both.

- True
- False

If a patient enters the office with a physician's order to have a screening mammogram performed, and something irregular is found on the film of the screening mammogram, the radiologist should ...

- Request that the patient return to the office the next day; bill Medicare for the screening mammogram for that day and diagnostic mammogram on the following day (when the patient returns).
- Immediately perform a diagnostic mammogram to confirm findings; bill Medicare for both the screening mammogram and the diagnostic mammogram (same date of service).
- Take additional views (or films) and only bill Medicare for the diagnostic mammogram.
- Contact the treating physician immediately.

Medicare allows coverage for women to have a screening pelvic exam at what interval?

- Once every year.
- Once every other year.
- Once every three years.
- Once in a lifetime.

Medicare will cover screening colorectal examinations provided:

- There is a written order from the attending physician.
- There is a medical need to perform the test.
- The patient/attending physician requests to have this procedure performed.
- None of the above.

True or False? The number "3" should be reflected in the number of days/units field when a provider bills Medicare for the fecal-occult blood test which required "3" simultaneous determinations.

- True
- False

You scored \_\_\_\_ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

1	2	3	4	5	6	7	8	9	10
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Your course "Progress Report" containing both the Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. Women's Health course certification is given to individuals scoring 90% or better on the Post-Course Knowledge Assessment.

Note: You may increase your final score by retaking the Post-Course Knowledge Assessment at any time. Click the Menu button to do this now.

(End of Women's Health Section)

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